Local Pathway for Child death: North Central London

CHECKLIST

Within 1-2 hours

Immediate Decision Making and Notifications

Child Dies in hospital or body taken to hospital

Community death of a child on a palliative care pathway

Death abroad/ at mortuary/ body at site / Community

Inform palliative care consultant

Designated Doctor/ Community paediatrician

Attending consultant paediatrician informed and or Trust Child Death lead informed (Kennedy Guideline samples may be taken if trained and remove medical devices)

Virtual initial information-sharing and planning meeting to take place before the family leave the emergency department (if feasible)

Key worker and support for family identified- consult with family on local services they are familiar with (Early help/oncology nurse etc)

- Discussion how best to support family
- Inform those with parental responsibility and allow them to be with the child as soon as possible
- Liaise with palliative care team/life force where appropriate
- Family issued with *'When a child dies'* NHSE book, key worker filled in on page 3- name and contact details
- Guidance and signposting

1. Consult with Medical Examiner. Can a death certificate be issued?

If not, refer to coroner (if referring to coroner no need to consult Medical Examiner)

2. Is there a need for a serious incident review? (may reconsider later in pathway)

Refer to local trust guidelines

3. Should a Joint Agency Response (JAR) be triggered?

TRIGGER
Discussion led by acute paediatric consultant on call +/- police

- Is due to external causes
- Is sudden with no apparent cause including SUD/IC
- Occurs in custody
- Suspicions that the death may have not been natural
- Stillbirth where no healthcare professional was in attendance

Local processes initiated e.g. Datix reporting or equivalent, social care referral may be needed (even if not a JAR)

CHECKLIST

Informing:

- Notification form (A) completed on e-CDOP and sent to local CDOP Single Point of Contact (SPOC)
  - Local CDOP selected based on where child was resident - SPOC can consult with other CDOPs if greater learning will be elsewhere
  - CHIS will be automatically notified
  - SPOC notifies relevant key partners including LA safeguarding lead of death who notify Child Safeguarding Practice Review Panel where appropriate
- Other notifications in line with local protocols

CDR partners notified, JAR triggered and plan for scheduling. Organised by local SPOC/LA

- SPOC to inform LA safeguarding lead of death.

Within 4-48 hours

Investigation and information Gathering (immediate)

Local SPOC Administrator: receives Notification Form (formally A) and sends out Reporting form (B) to relevant stakeholders

Investigation and formation gathering

If a JAR is triggered meeting (s) convened and if appropriate a virtual JAR can be undertaken, including: llead health professional or senior attending paediatrician, police investigator, duty social worker, MASH representatives

Venue appropriate to circumstances of death, initial planning meeting can be held within 24 hours

Acute sector to provide administrative support, unless there is already a team that does this

The lead health Professional/Designated Doctor should chair and coordinate the JAR

Within 3 months (longer if waiting for formal reports)

Child Death Review Meeting

- **Local SPOC also to consolidate reporting forms**
- **Learning Disabilities Mortality Review (LeDeR):**
  - SPOC to check all reporting forms to identify if the child has a learning disability (Domain A: factors intrinsic to the child).
  - If the child is 4-18 years old and has learning difficulties inform the LeDeR local area contact who will allocate a reviewer.
  - Contact details are: **www.bristol.ac.uk/sps/leder/notify-a-death/** or **0300 777 4774**.

CHECKLIST

Key worker consults family for any input into CDRM

Child Death Review Meeting –coordinated by acute trust

Flexible and proportionate as to how this is run. Location – determined by location most appropriate for learning

Reporting form's reviewed, Analysis form (previously C) drafted.

- *Hospital based deaths* – (ED/ paediatric intensive care/ward) – Most deaths occur in hospital or the child is brought in – enhanced hospital mortality review meeting
- *Palliative care/life force* – Invite relevant team as appropriate
- *Neonatal Unit death* – Perinatal mortality Review Group meeting
- *LeDeR reviewer:* Analysis Form submitted to the borough Local Area Contact where relevant.
- *Other:* – if appropriate – at special school/GP
- Includes discussion on bereavement support for family

Determine if there are any safeguarding concerns for child or family and report as appropriate

Key worker: feeds back to family outcomes of CDRM. Alert family to the NCL CDOP

Local SPOC Administrator receives Analysis Form (C) to forward to NCL CDOP. If more relevant to discuss at an alternative CDOP- discuss with relevant CDOP leads

Within 1 year (to await for themed panels)

Independent Review

NCL CDOP meeting- 4-5 times a year

Analysis Form (C) completed at NCL CDOP

Thematic Reviews

Annual neonatal meeting

- *Determine if there are any safeguarding concerns for child or family and report as appropriate*

Applies learning from National Database to local population

Data sent to the National Child Mortality Database

Key worker feeds back learning from the themed panel to the family